Date of Admission	Allergies	**CHILD INFORMATION RECORD**
Date of Discharge		**STATE OF MICHIGAN** Department of Human Services Bureau of Children and Adult Licensing

Name of Child (Last, First, Middle Initial)		Address (number and Street, Building/Apartment Number)		
Child's Date of Birth	Home Phone ( )	City	State	Zip Code

Father/Legal Guardian's Name		Home Phone	Mother/Legal Guardian's Name		Home Phone
Home Address (if not child's address)		Cell Phone	Home Address (if not child's address)		Cell Phone
City	State	Zip Code	City	State	Zip Code
Employer/School Name			Employer/School Name		
Address (Employer/School)			Address (Employer/School)		
City	State	Zip Code	City	State	Zip Code
Employer/School Phone		Daily Work/School Times	Employer/School Phone ( )		Daily Work/School Times

Name(s) of Person other than Parent or Legal Guardian to whom child may be released

BCAL-3731 (Rev. 10-07) Previous edition may be used.   **See Reverse Side**

I give permission to _____, licensed by the Department of Human Services

(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

Signature of Parent or Guardian	Date Signed

Name of Child's Physician or Health Clinic	Physician's or Health Clinic's Phone Number ( )
Address of Child's Physician or Health Clinic	Name of Health Insurance Carrier
Hospital Preferred for Emergency Treatment	Health Insurance Policy Number
Special Needs:	Date of Last DTaP (Diptheria, tetanus, pertussis) Shot
Name of Local Person to be Notified in an Emergency When Parents Not Available	Local Address of Emergency Person

Home and/or Cell Phone ( )	Work Number ( )	City, State	Zip code

Special Instructions:

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

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